MISSOURI
DEPARTMENT OF MENTAL HEALTH

ANNUAL SAFETY REPORT

Submitted to Governor Matt Blunt
July 2, 2007

STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH

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July 2, 2007

The Honorable Governor Matt Blunt
Lt. Governor Peter Kinder
The Missouri Mental Health Commission

Re: Annual Report on Implementation of Safety Recommendations

Dear Governor Blunt, Lt. Governor Kinder, and Commissioners:

During 2006, consumer safety emerged as a concern for individuals served by Department of Mental Health (DMH) facilities and programs. Both the executive branch of Missouri state government and the Mental Health Commission (MHC) initiated a review of the prevention and investigation of allegations of abuse and neglect within DMH services. The resulting recommendations have provided a template for action by the Department to improve safety for its consumers.

The Department of Mental Health has taken these recommendations very seriously and recognizes their importance in restoring the trust and confidence of consumers, families and other stakeholders. This report details implementation in the months since the recommendations were issued including specific accomplishments to date, status updates and continuing action items that promote safety for DMH consumers and identify improvements that will prevent abuse and neglect in the future.

Public service in the 21st century requires collaboration. The DMH safety initiative demonstrates the value of leadership that utilizes interagency collaboration to address complex problems. The Department of Mental Health extends its appreciation for your collective support. Without the leadership and expertise provided, the progress reported in the first annual safety report would not have been possible.

Sincerely,

Keith Schafer, Ed. D.
Director

Contents

Executive Summary

The Annual Safety Report provides a status update of Department of Mental Health (DMH) activities and accomplishments in implementation of 25 recommendations made by the Mental Health Task Force (MHTF) and contained in its November 2006 report. Governor Matt Blunt created the Mental Health Task Force in response to safety concerns in DMH facilities and programs. At Governor Blunt's Request, Lt. Governor Peter Kinder provided leadership to the Task Force, convening a series of public hearings and committee deliberations that resulted in a thoughtful series of recommendations to improve safety in DMH programs.

The Annual Safety Report provides an item-by-item summary of progress toward implementation of the report recommendations. Much has been accomplished in the months since the 11/06 release of the report. Implementation of:

- Ten of the MHTF recommendations have been completed.
- Two additional items are nearing completion.
- Eight additional recommendations are considered well underway.

Because the recommendations included both short and long term strategies for action, annual reports will be prepared and broadly disseminated as required by MHTF Recommendation #25.

Senate Bill 3

A great deal of the progress being reported in this first report is due to the legislative package contained in SB 3 referred to as Mental Health Reform. The bill was pre-filed by Senator Michael Gibbons on 12/1/06 and was passed by the General Assembly on 5/18/07. The bill included provisions to specifically address the following recommendations made by the MHTF:

MHTF Recommendation Number	SB 3 Provision	Status
2	Formal ties with state departments of Health and Senior Services' and Social Services' abuse reporting hotlines	 *
6	Fines & penalties for failure to implement plans of correction	
7	Fines & penalties for failure to report abuse or neglect	
13	Background checks and pending investigations	
14	Civil immunity for discussion of safety-related job performance	
15	DMH Fatality Review Board	
16	Public access to non-confidential final DMH investigation reports substantiating abuse/neglect	
23	Pursue legislation similar to elder abuse statutes	

** See Key on Page 9*

The bill becomes law on August 28, 2007, at which time DMH will be authorized to fully pursue full implementation actions including development and promulgation of any necessary rules, agreements and others necessary to carry out the provisions of the act.

FY 2008 Budget Appropriations Supporting Safety

The DMH budget for FY 2008 includes funding recommended by Governor Blunt and supported by the legislature for:

- Direct Care Staff Training (MHTF recommendation #4);
- Accreditation of MRDD state-operated facilities and community programs (MHTF recommendation #1); and
- Direct Care Salary Enhancements (MHTF recommendation #8).

Improvements in Investigations Processes and Quality

Significant progress has been made regarding improvements to assure that DMH can rapidly respond to reports of abuse and neglect through prompt and effective investigations. Ten of the MHTF recommendations specifically outlined actions to improve DMH investigations capacity and quality. Of those recommendations, five have been completed, one is nearing completion and two are well underway. The specific areas of focus by the MHTF are summarized in the table below.

MHTF Recommendation Number	Focus Area	Status
4	Improved and standardized training for investigators, incorporating law enforcement techniques and skills	 *
10	Use of root cause analysis for recurring or high risk incidents	
12	Promoting an understanding by investigators of their role in protecting consumer safety and the use of their recommendations for systemic solutions and improvements	
13	Establishing a mechanism to track individuals with investigation findings against them pending completion of due process appeals	
16	Providing public access to non-confidential final investigation reports	
17	Improved triage and prioritization of investigations	
18	Employee misconduct policy	
19	Implement sister agency recommendations, as feasible	
20	Determine appropriate workload for investigators	
22	Revise DMH written agreement with Missouri Protection and Advocacy	

** See Key on Page 9*

Mental Health Commission Report Recommendations

As MHTF recommendation #21, the MHTF recommended that DMH pursue implementation of the Mental Health Commission (MHC) recommendations made in their 8/06 report titled "Building a Safer Mental Health System." Twelve recommendations in the MHC report are not specifically addressed in the MHTF report. Four have been completed addressing:

- Separation of investigations from the Office of General Counsel
- Policy Directive to state-operated facilities regarding night and weekend on-site monitoring
- Leadership by DMH responsibility for budget and prioritization
- Augmentation of DMH executive team

The remaining eight recommendations are predominantly in early stages of study and implementation because they represent more preventive strategies for abuse and neglect requiring resource development and cultural change. These items include:

- Supervisory accountability
- Ombudsman programming
- Increased consumer and family voice
- Flexible funding options
- Video camera surveillance
- Drug and mental health courts
- Increase Crisis Intervention Training for law enforcement
- Comprehensive plan for mental health needs for aging consumers

Data Analytics for Safety

In future years, the Safety report will increasingly replace progress updates with performance reports summarizing leading edge indicators related to consumer safety in DMH. Only when the Department can effectively track its performance and outcomes related to safety will it be possible to:

- Rapidly identify programs and individuals where safety is a concern;
- Conduct necessary analysis to identify causal factors leading to unsafe conditions; and
- Apply resources in the form of training and improved processes consistent with quality improvement practices.

These are essential steps as the Department continually strives to "Do no harm." in the delivery of mental health services to Missourians with mental health conditions, developmental disabilities and substance abuse disorders.

Introduction

Purpose of Report

As the final recommendation in its November 2006 report to Governor Matt Blunt, the Mental Health Task Force (MHTF) mandated the creation of an annual safety report to be prepared by the Missouri Department of Mental Health (DMH). The annual report, due each year starting 6/30/07, is to be submitted to:

- The Governor;
- The Lt. Governor; and
- The Mental Health Commission (MHC).

Its purpose is to summarize DMH progress in implementing twenty-five (25) recommendations made by the Mental Health Task Force, developed after an exhaustive review and analysis of DMH operations as they relate to the safety of its consumers.

"It is the fundamental responsibility of government to protect its most vulnerable citizens. The task force recommendations are an important tool to help fulfil that responsibility and ensure Missourians receiving mental health service are not at risk of abuse or neglect."

- Governor Matt Blunt

The information contained in this document has been designed to satisfy the annual report requirement for FY 2007. The report also provides an opportunity for DMH to communicate its activities and progress toward improved safety for all DMH consumers. As part of the DMH commitment to the principle of transparency, this report becomes an additional tool to promote meaningful communication and information sharing with its stakeholders and the interested public.

Background Information

At A Glance:

- *Governor orders change*
- *MHC issues recommendations*
- *MHTF report issued 11/06*
- *Governor issues 12/06 executive order*
- *Mental Health Reform Bill*

In 2006, Governor Blunt responded swiftly to public concern about safety for DMH consumers. In addition to a set of directives that increased DMH accountability, he made available the resources and assistance of other state agencies to address the pressing safety concerns. Governor Blunt also appointed a Mental Health Task Force (MHTF) to be chaired by Lt. Governor Peter Kinder and co-chaired by Dr. Dittemore, the interim DMH director.

"I commend Governor Blunt and the Department of Mental Health for their work and dedication in making substantial and real changes in the Missouri mental health system" said Lt. Governor Peter Kinder. He added, "As Co-Chairman of the Governor's Mental Health Task Force, I was able to witness first-hand the dedication of Mental Health Department employees who work to meet the needs of consumers and their families. Important changes have been made, but it remains our duty to protect our most vulnerable Missourians from abuse and neglect."

- Lt. Gov. Peter Kinder

Also during this time, the Mental Health Commission, led by Dr. John Constantino, undertook a study process that resulted in a set of recommendations issued in August, 2006 outlining strategic actions that

would improve short-term and long-term safety outcomes for DMH consumers and increase transparency and accountability by DMH leadership.

Lt. Governor Kinder convened the task force to review best practices and make recommendations for changes to the mental health system to improve safety for DMH consumers. The series of meetings included public testimony at six locations across the state where nearly 300 Missouri citizens stepped forward to make their voices heard. After months of public dialogue and careful deliberation, the MHTF issued its report in November, 2006.

Additional details about the series of steps and activities undertaken at the time are well documented as part of the full MHTF report. In the intervening period of months since the MHTF report was issued, several events of note have occurred

- After reviewing the report, Governor Bunt issued an Executive Order (http://www.gov.mo.gov/eo/2006/eo06_049.htm) on 12/19/2006 outlining safety-related priorities for immediate action by the Missouri Department of Mental Health.
- On 12/1/07, Senator Mike Gibbons pre-filed SB 3, mental health reform legislation that incorporated as its emphasis many of the key recommendations offered by the Mental Health Task Force.
- A joint meeting between Lt. Governor Peter Kinder and members of the MHTF in conjunction with the Mental Health Commission was convened in January 2007 with focus on strategic collaboration.
- Keith Schafer assumed the role of director of DMH effective 2/1/07. Dr. Schafer has identified consumer safety as an important vision theme for DMH during his administration.

Mental Health Reform in the 94th General Assembly

President Pro Tem of the Senate, Senator Michael Gibbons introduced SB 3, known as "the mental health reform bill." The Senator made it clear that government leaders were emphatic about the need for change within DMH that would ensure safety for those participating in the services provided or purchased by the state.

> *"The reforms in SB3 will better protect our most vulnerable citizens. Their safety and quality of life is what is most important. They need our respect, care and support to keep them safe."*
>
> *- Sen. Michael R. Gibbons*

This act defines "vulnerable person" as any person in the custody, care, or control of the department that is receiving services from an operated, funded, licensed, or certified program. This act also creates the crime of "vulnerable person abuse" and provides for mandatory reporting of suspected vulnerable person abuse as well as investigation protocols. The bill:

- makes the final reports of substantiated Department of Mental Health abuse and neglect investigations at state facilities and contract providers issued on or after August 28, 2007, available as public documents, with restrictions on the release of any identifying information about clients and staff.
- increases the penalty for a mandated reporter not reporting abuse and neglect from an infraction to a Class A misdemeanor. This act also imposes sanctions and penalties on providers that prevent or discourage the reporting of abuse and neglect.
- gives civil immunity to employees of the Department of Mental Health and contract providers who engage in discussion with the intent to help ensure that facilities and providers are aware of past history of potential employees that might create a danger to clients.
- increases the penalty for community providers who do not correct problems cited by the Department of Mental Health in licensing inspections.
- establishes a mental health fatality review panel to review all suspicious deaths of clients of the Department of Mental Health.

As CCS HCS#2 SS SCS SB 3, Mental Health Reform legislation passed on May 18, 2007. Additional details about the bill, its provisions and its progress through the legislative process is available at the following link: http://www.senate.mo.gov/07info/BTS_Web/Bill.aspx?SessionType=R&BillID=162 With Governor Blunt's endorsement, the bill will be enacted as law on August 28, 2007.

FY 2008 Budget Appropriations Supporting Safety

Governor Blunt recommended key budget decision items to support safety in the FY 2008 budget cycle that were passed by the legislature. Specifically, the DMH FY 2008 budget includes funding for:

Safety-Related Decision Item	Appropriation Amount
Direct Care Staff Training *(including Network of Care funding as an online training infrastructure)*	$788,000
Accreditation of MRDD Facilities and Community Programs	$600,000
Direct Care salary increase of 3% *(This amount is in addition to the 3% Cost of Living Adjustment appropriated for all state employees.)*	$1,864,825
TOTAL	***$3,252,825***

These appropriations are directly related to critically important recommendations in the MHTF plan. The funds will provide important resources to support action steps and infrastructure development for DMH consumer safety.

Recommendations: Prioritization & Action Planning

With the support of the General Assembly in the form of legislation and funding, it was incumbent on the Department to develop an organizing framework for implementing recommendations, tracking progress and coordinating the complex network of activities to achieve improved safety for DMH consumers. In its analysis and work planning, the Department, in concert with the Commission, undertook a careful analysis of the impact and resource requirements for the recommendations.

At A Glance:
- *Identifying a starting point*
- *Moving to a comprehensive process*
- *Focusing on prevention of abuse and neglect*

The analysis resulted in clear definitions for two types of impact on consumer safety as described below:

- ▶ Actions that either prevent consumer abuse & neglect or improve consumer safety.
- ▶ Actions that result in rapid identification, reporting & responses that:
  - ■ Protect the affected consumer, and
  - ■ Identify individual or systemic solutions that make all consumers safer.

This clarity enhanced understanding of the results expected with implementation of each recommendation and promoted healthy discussion among decision-makers and stakeholders. These discussions also provide common language and expected results to support transparency and accountability in relation to Department performance for consumer safety.

Implementation Progress for MHTF Recommendations

Overview of Strategic Progress

At A Glance:
- *10 Recommendations completed!*
- *Tracking progress*

A great deal has been accomplished in the months since the release of the MHTF report. This section provides information about the progress that has been made toward implementation of each of the recommendations made by either the MHTF or the DMH Mental Health Commission (MHC). Comprehensive listings of both sets of recommendations are included as Appendix A and Appendix B of this report. For readers interested in detailed review of the reports, the full text of both reports is available online at the following web locations.

Report	***Web Address***
MHTF report	http://www.dmh.missouri.gov/mmhtaskforce/index.htm
Mental Health Commission	http://www.dmh.missouri.gov/spectopics/MHCreport.pdf

The summary table of progress to date for all MHTF recommendations on page 10 provides an at-a-glance view of the current status for all MHTF recommendations followed by an item-by-item progress description numbered to correspond to the MHTF numbers. Each progress update includes a table that uses the following key.

Progress Key

Implementation scheduled

Initial implementation underway

Implementation is well underway

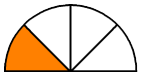
Final implementation phase and nearing completion

Recommendation completed

MHTF Mental Health Task Force
MHC Mental Health Commission
GEO Governor's Executive Order

Number	Recommendation	Status
1.	National accreditation of MRDD habilitation centers and contracted community providers	
2.	Formal ties with DHSS Adult Abuse & DSS Child Abuse hotlines	
3.	Standard individualized training for consumers and families on identifying and reporting abuse and neglect	
4.	Standardized training for all DMH and provider staff on identifying and reporting abuse and neglect.	
5.	Redesign DMH process for licensure and review of community-based providers within the next 12 months	
6.	Pursue legislation and amend regulations for administrative actions, up to and including fines, for failure to implement plans of correction.	
7.	Fines or other penalties against licensed, certified, or contracted entities for failure to report abuse and neglect.	
8.	Salary enhancement for direct care staff	
9.	Effectively track critical data on abuse, neglect, and other safety information.	
10.	Use of Root Cause Analysis (RCA) for complaints and issues which are recurring.	
11.	Commitment to providing public and community based services that afford real choices for all Missourians who require DMH services.	
12.	Review policies and procedures to ensure that consumer health, safety, and welfare are the first and foremost priorities of DMH staff	
13.	Background checks on all potential employees to determine whether the individual is the subject of a pending investigation.	
14.	Civil immunity to providers and DMH administrators allowing open discussion of individual job performance, etc.	
15.	DMH Fatality Review Board	
16.	Allow public access to non-confidential information in final reports of substantiated abuse and neglect, etc.	
17.	Triage of incidents for joint investigation of all deaths or near deaths that are suspect for abuse or neglect, etc.	
18.	Incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through disciplinary procedures.	
19.	Enhance DMH investigations process by evaluating recommendations from sister agencies on this Task Force and implementing all that are feasible.	
20.	Determine appropriate DMH investigation workload	
21.	Implement MHC report recommendations to fullest extent possible.	**In progress**
22.	Review and revise DMH Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services	
23.	Pursue legislation similar to elder abuse statutes	
24.	Public/private partnerships for MRDD services	
25.	Annual safety report to the Governor, the Lieutenant Governor, and the Mental Health Commission on implementation progress	

Recommendation # 1: Accreditation of MRDD Facilities and Programs

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue survey readiness towards national accreditation of its six habilitation centers and contracted community providers serving persons with developmental disabilities.	✔	✔	
Action to Date	**Status**		
• Governor supported DMH funding request for provider readiness surveys in FY 2008 budget • Legislature approved Decision Item in FY 2008 budget • Regional CARF & Council on Quality Leadership presentations scheduled for summer 2007 • Each habilitation center developing readiness work plan in collaboration with Division Leadership as part of MRDD's work plan			

Accomplishments: The concept of increasing care accountability through accreditation has been explored and accepted by MRDD habilitation centers and contract service providers. Both the Council on Quality Leadership and the Commission on Accreditation for Rehabilitation Facilities (CARF) are scheduled to make regional presentations regarding their standards and requirements during the summer of 2007. MRDD is discussing the process for the habilitation centers with each entity and a decision will be made by the Division regarding selection of the entity for accreditation for the habilitation centers. Survey readiness will identify status for each habilitation center is relative to the accreditation process. Outcomes of these efforts will be evaluated as the year progresses to determine need for additional infrastructure, staffing, programmatic and policy investments necessary to prepare for successful accreditation surveys. Based on the results of the readiness surveys, resource development and implementation strategies will be developed.

Recommendation # 2: Formal Ties with Hotlines

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall work with the Department of Health and Senior Services to establish formal ties to its adult abuse hotline, and with the Department of Social Services for formal ties to its child abuse hotline, so that reporters of abuse and neglect of DMH consumers fully utilize those hotlines as another means of reporting abuse and neglect. The Department shall then rigorously promote the use of these hotlines.	✔		✔

Action to Date	Status

• Included as a requirement of SB 3 pre-filed 12/1/06 & passed 5/07 with 8/28/07 effective date
• Joint meetings with DHSS since February, 2007 to develop written memorandum of understanding (MOU)
  ○ Relay of calls
  ○ Decision-tree for referrals
  ○ Definition crosswalk
  ○ Licensure collaboration & reporting
  ○ Electronic information exchange
  ○ Data collection & analysis
  ○ Periodic meetings for troubleshooting & quality improvement
  ○ Established electronic referral system and extended hours for immediate response to DHSS referrals
• Using framework of draft DHSS MOU, meetings scheduled to begin discussions with DSS hotline
	

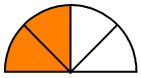
Accomplishments: Beginning in February, joint meetings between DMH and DHSS have taken place to prepare for use of the DHSS Adult Abuse Hotline as a redundant reporting methodology for abuse and neglect of DMH consumers. The goal has been to establish a Memorandum of Understanding (MOU) that outlines the methodology for receipt, handoff and prompt investigation of reports made to the DHSS hotline. A draft MOU is in final stages and will be prepared for signature of DHSS and DMH directors no later than early August. Necessary electronic and phone infrastructure to assure timely 24/7 response by DMH has been set up and tested for 8/28/07 full implementation. Modifications within the DMH "Event Management and Tracking" (EMT) system have been made to track referrals.

Using the draft MOU developed with DHSS as a template, DMH has scheduled meetings with DSS leadership to establish a framework for collaboration. The DSS MOU is targeted for completion by no later than 8/28/07.

Recommendation # 3: Training for Consumers and Families

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH facilities and community providers shall develop standard individualized training for consumers and families on identifying and reporting abuse and neglect, including their responsibilities as permissive reporters.	✔		✔

Action to Date	Status

• The Office of Consumer Safety (OCS), in conjunction with the program Divisions, has identified existing programs and materials to educate consumers and families regarding:
  ○ Identification of abuse/neglect
  ○ Reporting
  ○ Self-advocacy
  ○ Prevention from harm
• Work process designed to:
  ○ Evaluate content
  ○ Identify methodology for delivery of information using a variety of strategies
  ○ Identify methodology for content development of "curriculum"
  ○ OCS has been designated to convene a workgroup of consumers and families to review content
	

Accomplishments: Information and empowerment of consumers/families is regarded as an effective and powerful prevention tool related to abuse and neglect. Development work for a curriculum to educate families about abuse and neglect and inform them about self advocacy has begun and the projected date for providing materials to consumers is January 2008. The information will be provided to consumers and their families through a variety of media including distribution of written information, web posting, and online and live training events. An important principle for the work group will be the strategic delivery of information at critical times in an individual's treatment such as first time admission to a DMH facility or program, transfer to a more restrictive level of care, changes in residential facilities, or when treatment plans are modified or a behavior support plan is created.To increase the effectiveness of this strategy, DMH will explore use of consumers and families as trainers, modeling after already existing promising practices such as People First of Missouri, Self-Advocates Becoming Empowered (SABE), or Partners in Policymaking. Establishing partnerships with key advocacy groups such as National Alliance on Mental Illness (NAMI), People First, the Developmental Disabilities (DD) Council, Missouri Protection and Advocacy (MO P & A), and others will be another important strategy for intensifying training impact as well as extending resources for delivery of the information.

RECOMMENDATION # 4: STANDARDIZED TRAINING

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall amend its Departmental Operating Regulations (DORs) and administrative rules to require standardized training based on best practices for all DMH and provider staff on identifying and reporting abuse and neglect. Law enforcement expertise should be utilized in the development of such training. The Department of Mental Health shall also standardize training protocol for investigators that includes review of policies and procedures, supervision levels, and training on the Safety First manual. The Department shall implement a mentoring program for new investigators that will include teaming them with seasoned investigators.	✔		✔

Action to Date	Status

• Governor supported DMH funding request for staff training in FY 2008 budget
• DMH investigators trained
  ○ Using newly developed procedural manual based on consultation with law enforcement & other experts
  ○ By LRA, a nationally identified expert in the field of investigating abuse and neglect in mental health settings
  ⊙ DMH staff took competency-based test after training
  ⊙ 93.5% now credentialed by LRA
• Investigations unit implemented a pilot mentoring program in the St. Louis area beginning 4/16/07
• Legislature approved a decision item (DI)I in FY 08 budget in amount of $788,000
• Network of Care contract being amended to include E-learning as a component of the Missouri website in order to deliver training
• DMH Human Resources (HR) has been designated as lead for a work group to:
  ○ Develop training content
  ○ Explore and recommend dissemination of training
	

Accomplishments:

Related to the components of this recommendation that address investigator training, a great deal of progress has been made, including enhancements that were not originally anticipated as part of the recommendation.

- DMH staff developed and provided training for investigative staff that incorporated assistance from law enforcement personnel based on a revised procedural manual for the investigative unit.

- Labor Relations Alternatives, Inc. (LRA), a nationally recognized training and credentialing body that is a leader in the field of investigations related to abuse and neglect in mental

health settings, conducted two training seminars for investigations unit staff in the spring. LRA certifies investigators based on a competency-based post-test.

- Targeted recruiting by the Investigative Unit to hire people with law enforcement backgrounds as investigators has been successful, creating a specialized resource within the investigations unit. These individuals can then be assigned to match needs associated with investigations that will require extensive coordination or assistance with local law enforcement agencies or require complex evidence gathering and analysis.

- DMH has piloted a "Lead Investigator" process in the East (STL) region as another component of its implementation strategy. In addition to the regular performance expectations for a PS I/Investigator, the lead investigator is expected to: provide training/mentoring to new and less seasoned investigators and function as a backup for the supervisor in his/her absence. The effectiveness of this approach will be evaluated to assess expanded use of the model.

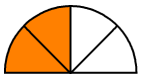
These components of the recommendation can be considered complete with remaining challenges related to sustainability of the efforts.

Related to the second component of the recommendation to train all staff on abuse and neglect, the funding included in the FY 08 budget will establish the foundation within DMH infrastructure for system-wide training through E-learning, an on-line staff development system as part of the Missouri Network of Care (NoC) site. The NoC contract is being amended in June, 2007, to add E-learning with expected availability in September, 2007. System setup and bandwidth enhancements will be required for full implementation. E-learning has the value-added capability to track and document staff training, an important accountability feature of this recommendation. During the first quarter of FY 08, DMH HR staff will convene a stakeholder group for development of abuse and neglect training for staff as the first component to be implemented using the E-learning venue.

Recommendation # 5:
Redesign of DMH Licensure and Certification

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall redesign its process for licensure and review of community-based providers within the next 12 months. The process should include a review of best practices from other states. Annual site visits to facilities should be mandatory. Part of this process should include routine communication between the Investigative Unit and the Division of MRDD so that facilities with increased numbers of allegations can be targeted for additional assistance in maintaining consumer safety.	✔		

Action to Date	Status

• Consultation with Human Services Research Institute (HSRI) by Division of MRDD includes discussion of:
  ○ licensure and certification models from other states;
  ○ recommendations received from HSRI in late December, 2006 to be considered in redesign
• Leadership for this DMH-wide work effort to be led by Division of Alcohol and Drug Abuse
	

Accomplishments: Discussions with the Human Services Institute has included a review of policies and procedures utilized within other states. Methodology for informal feedback relative to allegations will be formalized to ensure that information can be used proactively.

This effort will be integrated as part of a Department-wide update and redesign to licensure and certification processes. Key among considerations will be infrastructure and processes that support safety and well-being among DMH consumers. Primary focus areas will include:

- Frequency of on-site review for compliance with standards;
- Use of information from surveys for early identification of risk;
- Design of consultative and training strategies to promote safety for consumers; and
- Supplementation of licensure and certification with consumer and family education and advocacy efforts.

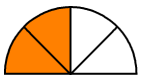
Recommendation # 6:
Penalities for Failure to Implement Plans of Correction

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation and amend regulations involving Licensure & Certification to permit administrative actions, up to and including fines, for failure to implement plans of correction.	✔		
Action to Date	**Status**		
• Authorizing language for this recommendation is included in SB 3 passed in 5/18/07 with an effective date of 8/28/07 • DMH action to be implemented based on recommendations of work group completing review referenced in Recommendation 5 above.			

Accomplishments: This provision was included in SB 3, the "mental health reform bill." This act increases the penalty for community providers who do not correct problems cited by the Department of Mental Health in licensing inspections. The current fine of 100 dollars per day will be increased to as much as 10,000 dollars per day. Similar penalties have been implemented in other states to promote compliance with regulatory provisions that enhance consumer safety. In order to implement this provision, rule changes to DMH licensure and certification will be needed. Amendments to the rules will be addressed as part of the stakeholder review of licensure and certification required in Recommendation #5 above.

Recommendation # 7:
Penalities for Failure to Report Abuse and Neglect

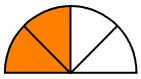
Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation and amend regulations that permit fines or other penalties against licensed, certified, or contracted entities for failure to report abuse and neglect, based upon organizational misconduct.	✔		

Action to Date	Status
• Authorizing language for this recommendation is included in SB 3 passed in 5/07 with an effective date of 8/28/07. • Plan in place to revise contracts and create the authority to penalize providers who are in violation of this.	

Accomplishments: This provision in SB 3, the "mental health reform bill." It increases the penalty from an infraction to a Class A misdemeanor for a mandated reporter failing to report abuse and neglect. This act also imposes sanctions and penalties on providers that prevent or discourage the reporting of abuse and neglect. Penalties similar to this in other states are regarded as effective prevention. Amendments to DMH regulations will be required to establish methodology for implementation. In addition, contract revisions will be needed to establish DMH authority to penalize providers that interfere with reporting of abuse and neglect.

Recommendation # 8: Enhance Direct-Care Salaries

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health must improve the quality of care by enhancing the salaries of direct care staff to be commensurate with the level of skill and responsibility required of those positions in both state operated and community based care.	✔		

Action to Date	Status
• With Governor's support, 94th General Assembly granted a 3% increase for DMH direct care employees in addition to a 3% COLA for all state employees, resulting in a 6% total increase effective July 1, 2007 • DMH presentation to 6/12/07 Personnel Advisory Board (PAB) advocating for additional direct care salary increases as part of their pay plan for FY 09 • DMH will explore additional budget strategies to improve salaries for direct care staff in the community and in state-operated programs and facilities	

Accomplishments: Reducing staff turnover, recruiting appropriate staff and communicating high expectations require adequate salaries commensurate with the skills, training, responsibilities and risks required for direct care staff. Salary increases for direct care staff was the number one issue at each of the six public hearings conducted by the Mental Health Task Force. DMH made this a priority item within the budget cycles noted above and received bipartisan support for the increased salaries. Beginning July 1, DMH direct care staff paychecks will reflect a 6% increase. In order to sustain the 3% increase afforded for direct care staff, a directive was developed and disseminated to facility heads to instruct that the additional 3% would apply to future new hires and promotional employees.

DMH submitted written testimony to the Personnel Advisory Board on 6/12/07 in support of additional salary advancements for direct care staff as part of its pay plan for FY 09. DMH will also explore decision items in the FY 09 budget to enhance direct care compensation and benefits.

Recommendation # 9: Data and Quality Improvement

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH must implement an information management system that can rapidly and effectively track critical data on abuse, neglect, and other safety information. This data will be used as a component of the Department's continuous quality improvement plan and the Department's annual report to the Governor and Lieutenant Governor. Additionally, information technology should be developed to integrate all state departments' data for tracking any facility related inspections, complaints, investigations, etc. for both public and community based care.		✔	✔

Action to Date	Status
• CIMOR implemented in October 2006. • The electronic data system called "Event Management and Tracking" (EMT) system was implemented in November 2006. • DMH Division staff are identifying consumer safety leading indicators for use in performance "scorecards" • DMH leadership has authorized development of data analytics for consumer safety	

Accomplishments: A vision theme established as part of the DMH strategic plan is to promote informed decision-making through data analytics. The application of data analytics to safety indicators is an important strategy for accountability and performance measurement. The implementation of CIMOR in 10/06 at DMH provides a foundation for development of data warehouses and data analytics to improve the quality and availability of data to DMH at all levels. Efforts are underway to identify safety-related data domains that are critical to define trends, successes and failures in consumer safety. The first phase of the work is to conceptualize and build constructs for these data elements. Development of leading edge indicators that reflect DMH consumer safety performance is underway. Once the conceptualization and operational protocols are established, data collection must be undertaken for baseline and future trending efforts. Building a DMH Consumer Safety Data Warehouse provides a valuable tool that will provide information and reports to support sustained quality improvements in the area of consumer safety.

Recommendation # 10: Root Cause Analysis

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall review completed investigations and explore Root Cause Analysis (RCA) for complaints and issues which are recurring. Root Cause Analysis should include, but not be limited to: examination of supervision levels and staffing and identification of facility system failures for both public and community based care.	✔		

Action to Date	Status
• Engaged in significant discussion with DSS about RCA use • RCA already used for qualifying critical events in Joint Commission on Accreditation of Healthcare Organizations(JCAHO) accredited CPS facilities • Just Culture session scheduled for 7/9/07 • Decision to initiate RCA as part of death review process	

Accomplishments: Root cause analysis (RCA) defines use of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is hoped that the likelihood of problem recurrence will be minimized. However, it is recognized that complete prevention of recurrence by a single intervention is not always possible. Thus, RCA may be applied as a tool several times for complex processes and is viewed as a tool of continuous improvement. Under the leadership of the Division of Comprehensive Psychiatric Services (CPS), efforts will be undertaken to establish policies for conducting Root Cause Analysis (RCA) for critical incidents including criteria for RCA use and the competencies of those to conduct the reviews. These efforts as well as associated data collection will require strategic coordination with consumer safety data analytics work.

As part of an increased emphasis on quality improvement and better preventive efforts related to consumer safety, investigations will explore aggregation methods to highlight trends and identify root causes of events. The DMH Investigative Unit (IU) has had triage staff review all death cases for 2006. IU is currently conducting a 100% review of all completed investigations at a targeted facility. When that review is complete, IU will work with the DMH Division staff to use RCA to determine the presence of systemic issues.

A training session that overviews a hospital patient safety program called “Just Culture” has been scheduled for 75 key DMH staff as well as diverse stakeholders for its applicability as a strategy for consumer safety. Just Culture relies on a decision algorithm that distinguishes individual performance failures from systemic problems. The congruence of the use of root cause analysis strategies with the Just Culture model provides the opportunity to increase reliance on data driven decisions and to dramatically improve safety results for DMH consumers.

Recommendation # 11: Real Choices and Range of Services

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall make a clear and unequivocal commitment to providing public and community-based services that afford real choices for all Missourians who require DMH services. Because it is recognized that various types of care are needed for different individuals, the Department shall provide services on a person by person basis.	✔	✔	
Action to Date	**Status**		
• Ongoing public dialogue with consumers and families. • Governor's Plan for Bellefontaine Habilitation Center (BHC) introduced in March 2007 • DMH FY 2008 budget includes funding for services to high-need individuals on MRDD waiting list			

Accomplishments: Statements and actions by Governor Blunt, Dr. Schafer and the Mental Health Commission have been unequivocal in their support of a range of services and choices for individuals served by the Department. Ongoing conversations with consumers and their families have taken place in a number of venues: advisory councils for CPS and ADA, the DD Council and Missouri P&A, the transformation workgroup of consumer and family voice, and the Director's mentoring group of consumers and family. Sustained efforts will continue to expand the range of choices available to consumers and to increase availability of services in response to consumer demand.

Recommendation # 12: DMH Commitment to Safety

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall review its policies and procedures, and ensure that the health, safety, and welfare of all its consumers are the first and foremost priorities of all employees -- investigators as well as the clinical staff -- of the Department. The Department's complaint investigation procedures need to be evaluated for effectiveness (including the benefits of allowing unannounced investigations) and a system put into place whose primary role is to assist in the prevention of abuse and protection of consumers through the investigation of abuse, neglect and misuse of funds.	✔		
Action to Date	**Status**		
• Strategic plan and DMH Director committed to safety vision theme • Investigation process has been revamped and systematized • New director of investigations directed to focus on quality improvement and preventive strategies			

Accomplishments: Dr. Schafer has reiterated the importance that each employee be concerned about and committed to consumer safety. It is a primary and guiding principle communicated as an important vision theme and incorporated in the DMH strategic plan finalized in June, 2007.

As a result of reviewing the DMH Investigative process and comparing this with best practices within the field, considerable change has been instituted. The entire Policy and Procedures manual has been rewritten to reflect best practice and effective function within the DMH system. Checklists and templates have been added to increase fidelity to policy and to improve efficiency of investigations. Suggestions from other state agencies have been incorporated into the revised procedures as well. This recommendation is regarded as fully implemented with intent to sustain and utilize established procedures to enhance quality of investigations consistent with advances in investigative technologies.

Recommendation # 13: Additional Background Checks

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall amend its regulations to create a process to require providers to conduct background checks on all potential employees to determine whether the individual is the subject of a pending investigation or finalized abuse or neglect case involving disqualifying events and require the provider to take appropriate steps to provide consumer safety.	✔		
Action to Date	**Status**		
• A reporting method to identify individual alleged perpetrators has been developed. • Tracking capability established within EMT. • Legal analysis to be conducted on disclosure before appeal process exhausted and any potential impact of SB 3 provisions.			

Accomplishments: The intent of this recommendation was to ensure that individuals would not be able to leave one job under allegations of abuse and neglect and move to another. The data system in place has been revised to include the capability of tracking individual names associated with investigations that are in process and those that have resulted in a finding of substantiated. However, in recognition of the importance of due process, DMH practice has been to place individuals on the employment disqualification list only after all appeals have been exhausted. Discussions are underway to determine if the existence of an ongoing investigation or its outcome can legally be disclosed prior to completion of all due process.

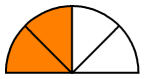
Recommendation # 14:
Civil Immunity for Employer Discussion of Performance

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation providing civil immunity to providers and DMH administrators allowing open discussion of individual job performance in order to make employment decisions that affect the safety of consumers. However, the legislation shall not protect reckless, misleading communication or intentional misstatements.	✔		
Action to Date	**Status**		
• Included as a requirement of SB 3 pre-filed 12/1/06 & passed 5/18/07 with 8/28/07 effective date.			

Accomplishments: The Mental Health Reform Act gives civil immunity to employees of the Department of Mental Health and contract providers who engage in discussion with the intent to help ensure that facilities and providers are aware of past history of potential employees that might create a danger to clients. The intent is to protect the rights of all, ensuring that failure to disclose documented poor performance will not increase potential danger to vulnerable consumers served by DMH and providers. With the passage of this legislation and the Governor's signature, this will become effective August 28, 2007. DMH will need to develop and file rules to fully implement this provision of the law.

Recommendation # 15: Death Review Board

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall craft a legislative proposal comparable to that which created Child Fatality Review Boards within the Department of Social Services. It would establish review of all deaths of adults who are in the care and custody of the Department of Mental Health. The board should include the expertise of pathologists or medical examiners, law enforcement, prosecutors, and advocates, including Missouri Protection & Advocacy Services.	✔	✔	✔

Action to Date	Status
• Report death to law enforcement on a routine basis • Discussions regarding details have occurred regularly with DSS • Contracted with retired Highway Patrol officer for review of death cases • Included as a requirement of SB 3 pre-filed 12/1/06 & passed 5/18/07 with 8/28/07 effective date.	

Accomplishments: Reporting deaths to law enforcement has now become routine and standard within DMH. The DMH Investigative Unit has been contracting with a retired Highway Patrol Officer who was in criminal investigations with the Patrol. It has been very helpful to have "law enforcement communicating with law enforcement." Contacts with a variety of agencies including the Fire Marshall and Alcohol, Tobacco and Firearms personnel has led to increased cooperation and many barriers have been resolved.

SB 3 establishes a mental health fatality review panel to review all suspicious deaths of clients of the Department of Mental Health. The inclusion of this provision in the statute will provide the opportunity to standardize death review and create a tool for aggregation and trend analysis that will inform DMH safety improvement efforts. The Fatality Review Board will be modeled after the one established in DSS for child death review and will be adapted to DMH responsibilities to its consumers. The Review Board will convene and review aggregate data and select cases that highlight systemic issues or highly complex scenarios that require expert objective analysis by a multidisciplinary team. Since August of 2006, DMH has met regularly with DSS staff to plan regarding this provision and will continue to use their expertise as implementation proceeds.

Recommendation # 16:
Public Access to Final Reports Substantiating Abuse and Neglect

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall pursue legislation to allow public access to non-confidential information in final reports of substantiated abuse and neglect.	✔	✔	
Action to Date	**Status**		
• Included as a requirement of SB 3 pre-filed 12/1/06 & passed 5/07 with 8/28/07 effective date. • Planning to amend 2.205 and 2.210 for compliance			

Accomplishments: To regain public confidence and ensure maximum safety for state provided or funded consumers, the DMH investigation process must be as transparent as possible while keeping in mind the need to protect individual rights of all involved. Under current law the findings of abuse and neglect investigations conducted by the DMH are confidential and reports of the investigations can only be issued to the parent or guardian of the client who is the subject of the investigation. SB 3 will increase public accessibility to the reports of substantiated DMH abuse and neglect investigations at state facilities and contract providers issued on or after August 28, 2007. These reports will be available with restrictions on the release of any identifying information about clients and staff. DMH will amend its Department Operating Regulations to comply with SB 3 and will train staff and providers regarding implementation of the new provisions.

Recommendation # 17:
Process Improvements for DMH Investigations Protocols

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall develop a process for triage of incidents for joint investigation of all deaths or near deaths that are suspect for abuse or neglect, as well as incidents of physical assault and sexual misconduct. In order to conduct "triage," strict procedural guidelines must be developed to allow for proper prioritizing of cases. This process should include notification of and cooperation with local law enforcement.	✔	✔	✔

Action to Date	Status

• Contracted with retired Highway Patrol officer for triage
• Hired additional support staff
• Located staff in regions for improved response time
• Investigation requests that are received involving allegations of criminal misconduct will be referred by the IU intake to Triage Staff for review, including but not limited to:
  ○ Deaths or near deaths that are suspect for abuse or neglect
  ○ Physical assault
  ○ Sexual misconduct
• In instances where it is believed that criminal misconduct has occurred, Triage Staff will coordinate a joint investigation with the appropriate law enforcement agency
	

Accomplishments: In the past there was limited collaboration between law enforcement and DMH investigators. By contracting with a retired highway patrol officer, improved cooperation has evolved. Cases are targeted at intake for triage assessment as necessary. This paves the way for evidence protection and additional precautions to ensure investigative integrity. Federal guidelines for Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) mandate that the results of all investigations must be reported to the facility administrator within five working days. DMH policies and procedures have been revised to improve timelines and outcomes.

Recommendation # 18: Administrative Disciplinary Procedures

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH and providers must ensure that incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through disciplinary procedures— though still tracked in the Department's information systems and monitored by executive staff. This would allow investigators to improve consumer safety by dedicating themselves to harmful incidents of abuse or neglect.	✔		
Action to Date	**Status**		
• Drafts of employee misconduct policies drafted and revised • DOR promulgated and revised based on field review and comment. • DOR on employee misconduct finalized in June for July 1, 2007 implementation. • Competency-based training required for facility staff, investigators, determiners and data entry during June 2007. • Investigative unit has developed quality control and feedback tools for determiners for initial implementation period.			

Accomplishments: The Mental Health Task Force identified the fact that 48% of all substantiated investigations are alleged to be Class II Neglect, events that typically involved no injury to the consumer. These events are actually employee misconduct and need to be managed by supervisors rather than by a trained, certified investigator with law enforcement expertise. These matters have been assigned appropriately to the realm of supervisory oversight and discretion to those with line authority. After July 1 2007, employee misconduct will be handled through supervision and facility-based processes. This allows for quicker local response to reported misconduct incidents and frees up investigative resources for potential abuse and neglect. Policies have been revised to reflect this approach and training was completed in June for all staff in facilities.

To establish a single standard in the community will require changes to DMH regulations for community providers. DMH is committed to a single standard of safety performance and data collection. However, the process for revising the standard in community settings requires several months. Leadership agreed that the change should be implemented as soon as possible, resulting in a phased implementation approach.

Recommendation # 19:
Sister Agency Investigations Improvement Recommendations

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall enhance its investigations process by evaluating recommendations from the sister agencies on this Task Force and implementing all that are feasible.	✔		✔
Action to Date	**Status**		
• On 9/15/06, DHSS submitted recommendations in a report after period of joint investigations • On 9/27/06 DSS submitted recommendations following co-investigations • Review and consideration of DHSS and other recommendations for implementation			

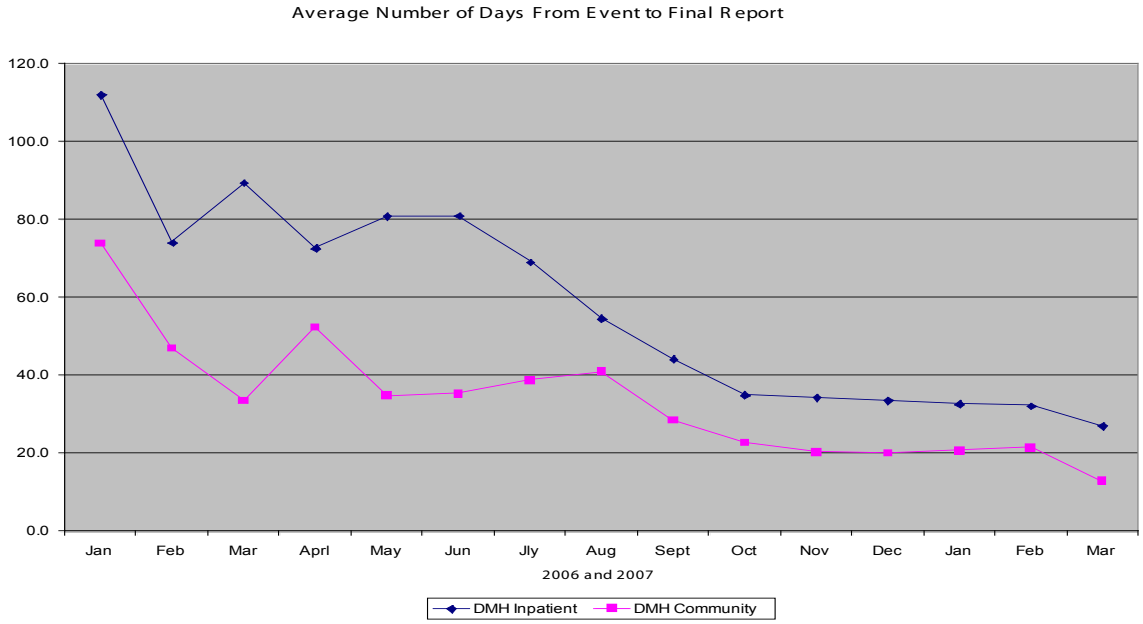
Accomplishments: After a period of joint investigations between DHSS and DMH, DHSS submitted a set of recommendations for DMH consideration. As a result of their recommendations, some changes were made in DMH investigatory protocol and practice. In addition, recommendations made by Mr. Kolilis of the DSS STAT team and others as part of the MHTF meetings were considered for implementation. Their support and expertise have been helpful and have improved operational aspects of DMH investigations.

RECOMMENDATION # 20: DMH INVESTIGATION RESOURCES

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall evaluate the number of investigations completed by the Investigations Unit and determine the appropriate number of investigators needed in order to meet current mandated time frames, without sacrificing the quality of the investigation. Interviews shall be initiated within the first day of the investigation.	✔		

Action to Date	Status
• Hired 4 new investigators • Reviewed investigative workloads • Located investigators across the state • Adjust workloads weekly	

Accomplishments: When the Mental Health Task Force was formed, there was a backlog of 418 investigations. By January 1, 2007, the backlog had been eliminated. This involved adding staff, changing some staff responsibilities, increasing training, re-aligning the investigative process for efficiency and operating with transparency. Workloads are reviewed daily so that staff can be deployed as necessary to ensure an appropriate response. The current average investigative caseload is 5 per investigator, but this can vary depending on the intensity, complexity, and extent of the allegations. The Department is in substantial compliance with the federal mandate requiring a response to the administrator of the ICF/MR within 5 working days. The chart below provides a graphic representation of the progress in terms of timeliness.

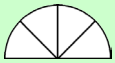
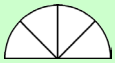
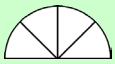


Recommendation # 21:
Implement Mental Health Commission Recommendations

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
DMH shall work with the Mental Health Commission to implement the Commission's recommendations to the fullest extent possible.	✔		

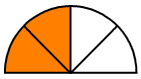
Action to Date	Status
• All recommendations were reviewed and screened for impact and feasibility to determine priorities.	In progress as noted in summary chart

Accomplishments: Recommendation 21 by the Mental Health Task Force supported the recommendations from the Mental Health Commission contained in their report titled "*Building A Safer Mental Health System.*" Twelve recommendations in that report are not addressed in the MHTF findings. Progress toward implementation of these ten items is summarized in the chart that follows.

Mental Health Commission Recommendation	Action to Date	Status
DMH must separate investigations from legal counsel	The Investigative Unit was reassigned to the Deputy Director's office as a discrete and separate work unit effective March 1, 2007	
Increase expectations for Supervisors related to abuse & neglect reports	A number of initiatives are underway to shift culture including: ○ Employee Misconduct ○ Training ○ Just Culture ○ Policy revision	
Make internal & external ombudsman available to consumers/families as well as phones for access	Options are being evaluated.	
Explore options for family and natural supports in all aspects of DMH service delivery	The Transformation has several recommendations for wrap-around and natural supports philosophy being infused in mental health service delivery	
Facility directors to be present during night/ weekend shifts at the facility	Directive issued by Felix Vincenz on 12/29/06 clarifying night and weekend coverage for facilities.	
When funding is inadequate to provide services, the scope of service must be reduced, all notified and decisions made by Director of DMH	As he assumed the role of DMH director on 2/1/07, Dr Schafer recognizes his responsibility in collaboration with his executive team, to manage resources and services consistent with quality and safety outcomes.	
Support for flexible funding including the concept that "money follows the person" to maximize choices	MRDD transformation initiative; DMH transformation initiative; DSS/DHSS/DMH $ follows the person demonstration grant: all these grant initiatives support this concept.	
Augment the DMH Executive Team	DMH Executive Team reconfigured and broadened February 2007; cross-divisional representation and others participate regularly.	
Consider video camera surveillance for all DMH facilities	DMH compiling additional research to determine feasibility and return on investment.	
Develop drug and mental health courts as diversion from incarceration	Some drug and mental health courts presently operational in pilot programs; CPS is exploring the most effective way to proceed with this.	
Expand Crisis Intervention Training (CIT) to prevent inappropriate incarceration	This is regarded as a best practice and funding was requested in the FY 2008 budget to support this training.	
Develop a comprehensive plan to meet the mental health needs of aging DMH clients.	The Transformation initiative is preparing a comprehensive plan across the lifespan; 1 FTE hired 3/16/07 who is a specialist in geriatric needs and strategies.	

RECOMMENDATION # 22:
UPDATE AGREEMENT WITH MISSOURI PROTECTION AND ADVOCACY

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health's Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services (P&A) shall be reviewed and amended if necessary to clarify roles and expectations. The terms of the MOU shall be made broadly available and become part of orientation and annual training for employees, consumers, and families.	✔		✔

Action to Date	Status
• Three meetings have been scheduled and two have taken place with P & A • Side by side comparison of current agreements and federal advocacy laws completed • Line by line review of integrated single agreement draft being reviewed by MRDD and CPS community provider representatives as well as state-operated facility representation	

Accomplishments: Federal legislation has established guidelines for protection and advocacy systems in every state and territory to assist with the responsibility of protecting the rights of individuals with disabilities. The Governor-designated system in this state is Missouri Protection & Advocacy Services (P&A). An analysis has been completed of federal law and the existing MOU with P & A following two meetings. A draft MOU is under review by the Divisions as well as provider representatives. This is the first agreement with P&A to involve the community provider networks of CPS and MRDD. Because most community providers have had limited experience with P&A, training is also a topic of discussion to promote increased understanding of their role and responsibilities with DMH consumers.

Recommendation # 23:
Pursue Legislation Similar to Elder Abuse

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall pursue legislation to amend Sections 565.180, RSMo, et. seq., which pertains to the crime of elder abuse, to incorporate the crime of patient, resident, or client abuse or neglect of a Department consumer currently provided for in Section 630.155, RSMo.	✔		
Action to Date	**Status**		
• SB 3 pre-filed on 12/1/06 as Mental Health Reform • The bill, as amended, passed 5/18/07 with 8/28/07 effective date			

Accomplishments: This act defines "vulnerable person" as any person in the custody, care, or control of the department that is receiving services from an operated, funded, licensed, or certified program. This act also creates the crime of "vulnerable person abuse" and provides for mandatory reporting of suspected vulnerable person abuse as well as investigation protocols. This will be effective August 28, 2007.

Recommendation # 24:
Public/Private Partnerships for MRDD Case Management

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health, Division of Mental Retardation/ Developmental Disabilities (MRDD), shall create a committee of key stakeholders to evaluate the feasibility of public-private partnerships to deliver case management services, determine eligibility, manage local wait lists, and provide and/or contract for a system of programs and services in their local areas.	✔	✔	✔

Action to Date	Status
• MRDD convened a representative group to consider all aspects specified in this recommendation. • Six meetings held and recommendations developed. • Written report completed and submitted on May 1, 2007.	

Accomplishments: MRDD established a committee to complete this task with diverse stakeholder involvement. On May 10, 2007, their work was presented to the Mental Health Commission. The entire report can be viewed at http://www.dmh.mo.gov/mrdd/stakeholder24.htm. The Committee has determined that it is feasible for the Division of MRDD to establish contracts with administrative entities to provide targeted case management and other services now being provided by regional centers. The report outlines a series of recommendations and principles to guide the implementation work. In their recommendations, the Committee recognized the transition process will be long term. However, the committee believes it is a worthwhile that will expand available resources by coordinating local, state, federal funding, and private donations at the community level.

Recommendation # 25: Annual Safety Report

Full Recommendation	Recommendation Report Source(s)		
	MHTF	MHC	GEO
The Department of Mental Health shall prepare an annual report to the Governor, the Lieutenant Governor, and the Mental Health Commission on its progress in implementing these recommendations. It shall include data that indicates the level of safety in the mental health system, along with plans for additional action where needed. The first report shall be submitted on or before June 30, 2007.	✔		✔
Action to Date	**Status**		
• A tracking system for monitoring implementation has been developed and utilized			

Accomplishments: This document constitutes the first annual progress report on the DMH implementation of the recommendations from the Mental Health Task Force, the Mental Health Commission and the Governor's office. The report provides a tool for sustained attention to consumer safety as a pre-eminent responsibility of DMH and supports accountability and transparency for matters related to safety. The next report is due 6/30/08.

Conclusion

When Dr. Keith Schafer assumed leadership as Director of the Department of Mental Health, he asserted that as the first of seven vision themes, DMH must "do no harm." In further elaboration of the department's commitment to safety, he has stated that "Consumers and their families must not fear greater risk of harm from DMH services than the condition that brought them to seek help from DMH."

Appendices

APPENDIX A: Mental Health Task Force Recommendations

Members of the Mental Health Task Force, Chaired by Lt. Governor Peter Kinder

Note: The recommendations that follow are from the report of the Mental Health Task Force. The full report, with recommendations and justification can be viewed at: http://www.dmh.missouri.gov/mmhtaskforce/index.htm

Recommendations

1. The Department of Mental Health shall pursue survey readiness towards **national accreditation** of its six habilitation centers and contracted community providers serving persons with developmental disabilities.

2. The Department of Mental Health shall work with the Department of Health and Senior Services to establish **formal ties to its adult abuse hotline**, and with the Department of Social Services for formal ties to its child abuse hotline, so that reporters of abuse and neglect of DMH consumers fully utilize those hotlines as another means of reporting abuse and neglect. The Department shall then rigorously promote the use of these hotlines.

3. The Department of Mental Health and community providers shall develop standard individualized **training for consumers and families** on identifying and reporting abuse and neglect, including their responsibilities as permissive reporters.

4. The Department of Mental Health shall amend its Departmental Operating Regulations (DORs) and administrative rules to require **standardized training** based on best practices for all DMH and provider staff on identifying and reporting abuse and neglect. Law enforcement expertise should be utilized in the development of such training. The Department of Mental Health shall also standardize training protocol for investigators that includes review of policies and procedures, supervision levels, and training on the Safety First manual. The Department shall implement a mentoring program for new investigators that will include teaming them with seasoned investigators.

5. The Department of Mental Health shall **redesign its process for licensure and review** of community-based providers within the next 12 months. The process should include a review of best practices from other states. Annual site visits to facilities should be mandatory. Part of this process should include routine communication between the Investigative Unit and the Division of MRDD so that facilities with increased numbers of allegations can be targeted for additional assistance in maintaining consumer safety.

6. The Department of Mental Health shall pursue legislation and amend regulations involving Licensure & Certification to permit **administrative actions**, up to and including fines, **for failure to implement plans of correction**.

7. The Department of Mental Health shall pursue legislation and amend regulations that permit **fines or other penalties** against licensed, certified, or contracted entities **for failure to report abuse and neglect**, based upon organizational misconduct.

8. The Department of Mental Health must improve the quality of care by **enhancing** the **salaries of direct care staff** to be commensurate with the level of skill and responsibility required of those positions in both state operated and community based care.

9. The Department of Mental Health must implement an information management system that can rapidly and effectively **track critical data** on abuse, neglect, and other safety information. This data will be used as a component of the Department's **continuous**

quality improvement plan and the Department's annual report to the Governor and Lieutenant Governor. Additionally, information technology should be developed to integrate all state departments' data for tracking any facility related inspections, complaints, investigations, etc. for both public and community based care.

10. The Department of Mental Health shall review completed investigations and explore **Root Cause Analysis** for complaints and issues which are recurring. Root Cause Analysis should include, but not be limited to: examination of supervision levels and staffing and identification of facility system failures for both public and community based care.

11. The Department of Mental Health shall make a clear and unequivocal commitment to providing public and community based services that **afford real choices** for all Missourians who require DMH services. Because it is recognized that various types of care are needed for different individuals, the Department shall provide services on a person by person basis. To that end, no habilitation center shall be closed as long as there is a need for its continued operation. Conversely, any habilitation center for which there is no need shall be closed.

12. The Department of Mental Health shall review Department policies and procedures, and ensure that the **health, safety, and welfare of all its consumers are the first and foremost priorities of all employees** -- Investigators as well as the clinical staff -- of the Department. The Department's complaint investigation procedures need to be evaluated for effectiveness (including the benefits of allowing unannounced investigations) and a system put into place whose primary role is to assist in the prevention of abuse and protection of consumers through the investigation of abuse, neglect and misuse of funds.

13. The Department of Mental Health shall amend its regulations to create a process to require providers to conduct **background checks** on all potential employees to determine whether the individual is the subject of a pending investigation or finalized abuse or neglect case involving disqualifying events and require the provider to take appropriate steps to provide consumer safety.

14. The Department of Mental Health shall pursue legislation providing **civil immunity** to providers and DMH administrators allowing open discussion of individual job performance in order to make employment decisions that affect the safety of consumers. However, the legislation shall not protect reckless, misleading communication or intentional misstatements.

15. The Department of Mental Health shall craft a legislative proposal comparable to that which created Child Fatality Review Boards within the Department of Social Services. It would establish **review of all deaths of adults who are in the care and custody of the Department of Mental Health**. The board should include the expertise of pathologists or medical examiners, law enforcement, prosecutors, and advocates, including Missouri Protection & Advocacy Services.

16. The Department of Mental Health shall pursue legislation to allow **public access to non-confidential information in final reports** of substantiated abuse and neglect.

17. The Department of Mental Health shall develop a process for **triage of incidents** for

joint investigation of all deaths or near deaths that are suspect for abuse or neglect, as well as incidents of physical assault and sexual misconduct. In order to conduct "triage," strict procedural guidelines must be developed to allow for proper prioritizing of cases. This process should include notification of and cooperation with local law enforcement.

18. The Department of Mental Health and providers must ensure that incidents not impacting consumer safety as defined and enforced by Department policy are handled administratively through **disciplinary procedures**— though still tracked in the Department's information systems and monitored by executive staff. This would allow investigators to improve consumer safety by dedicating themselves to harmful incidents of abuse or neglect.

19. The Department of Mental Health shall enhance its investigations process by evaluating **recommendations from the sister agencies** on this Task Force and implementing all that are feasible.

20. The Department of Mental Health shall evaluate the number of investigations completed by the Investigations Unit and determine the **appropriate number of investigators** needed in order to meet current mandated time frames, without sacrificing the quality of the investigation. Interviews shall be initiated within the first day of the investigation.

21. The Department of Mental Health shall work with the Mental Health Commission to **implement the Commission's recommendations to the fullest extent possible**.

22. The Department of Mental Health's **Memorandum of Understanding (MOU) with Missouri Protection & Advocacy Services** shall be reviewed and amended if necessary to clarify roles and expectations. The terms of the MOU shall be made broadly available and become part of orientation and annual training for employees, consumers, and families.

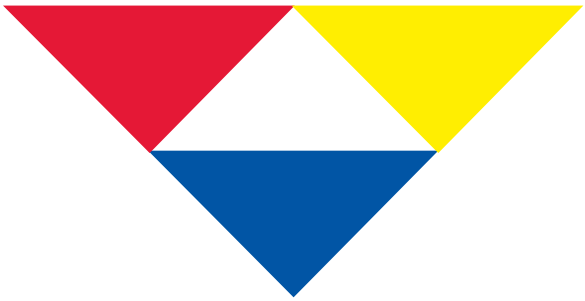
23. The Department of Mental Health shall **pursue legislation** to amend Sections 565.180, RSMo, et. seq., which pertains to the crime of elder abuse, to incorporate the crime of patient, resident, or client abuse or neglect of a Department consumer currently provided for in Section 630.155, RSMo.

24. The Department of Mental Health, Division of Mental Retardation/ Developmental Disabilities (MRDD), shall create a committee of key stakeholders to evaluate the feasibility of **public-private partnerships to deliver case management services**, determine eligibility, manage local wait lists, and provide and/or contract for a system of programs and services in their local areas.

25. The Department of Mental Health shall prepare an **annual report** to the Governor, the Lieutenant Governor, and the Mental Health Commission on its progress in implementing these recommendations. It shall include data that indicates the level of safety in the mental health system, along with plans for additional action where needed. The first report shall be submitted on or before June 30, 2007.

APPENDIX B: Mental Health Commission Recommendations

Missouri Mental Health Commission



Note: The recommendations that follow are from the report of the Mental Health Commission. The full report, with issues and recommendations can be viewed at: http://www.dmh.missouri.gov/spectopics/MHCreport.pdf

Recommendations

1. **Accreditation** of all habilitation centers should be pursued immediately. The level of accreditation should be commensurate with complex medical and mental health needs of persons that utilize these facilities. This includes provision and oversight for medical personnel and for training of staff to manage mentally ill patients. Similarly, an appropriate and feasible method for accrediting those community service providers who have not yet achieved accreditation must be pursued.

2. Information management methods must be implemented to rapidly and effectively **track critical data on abuse, neglect and safety** information. This means that all such data is organized in such a way that clusters of incidents are readily identifiable and reviewed by a member of the executive team. A dedicated information management staff should be appointed with responsibility to maintain surveillance over these events. If it is possible to dovetail this system with CIMOR (Consumer Information Management and Outcomes Reporting, the department's new management information system), it will be ideal since safety information and other indices of quality and utilization of care will allow for powerful resolution of weaknesses in the system. A critical aspect of the management of abuse, neglect and safety information must be to cross-refer data that is acquired in primary reporting systems with that acquired through back-up systems (see #4), to ensure integrity of the flow of control information.

3. There must be a proper **balance of investigative responsibility** that incorporates external resources (such as law enforcement, outside consultants, or other Missouri departments, etc.) to supplement internal investigation functions. Internal and external investigative functions in combination yield the best results maximizing the benefits of both. The primary responsibility for investigation of most serious incidents related to abuse, neglect or client safety should be placed with external review mechanisms to eliminate the appearance of a conflict of interest.

4. Every DMH facility and residential service provider must be held responsible for instituting and monitoring a fail-safe methodology for **timely reporting** of crucial incidents to Central Office. Such methods should include clear duality in the pathways through which this critical information flows. The submission of dual reports (one to facility leadership, the other to DMH Central Office), even if highly summarized (e.g., a mailed or electronically- submitted communication card), would allow for surveillance over the appropriate handling of such reports, and would protect against the information being dismissed or sequestered by administrators. All staff should be educated regarding the pathways of flow of the information. Thresholds for moving information to higher levels of authority must be clarified system-wide and specific protocols for reporting abuse and neglect information to the Mental Health Commission should be established.

5. The Department of Mental Health must **separate the internal authority for investigative procedures from its legal counsel**, in order to alleviate the inherent conflict of interest that is created when those who are charged with protecting the Department's legal interests are simultaneously charged with investigative authority.

6. The Department of Mental Health should aggressively support and facilitate the creation of **legislation to allow for non-confidential information regarding abuse and neglect to be made public**. The information should be analyzed and structured for ease of use by stakeholders, similar to formats used in public financial statements or annual reports. However, the department must be diligent in its analysis and presentation of the data to assure that it is fair, accurate, and respectful of the privacy of consumers and their families.

7. As a matter of policy, a fixed proportion of facility operating expenses should be set aside for the exclusive purpose of supporting continuing education and **training of staff**.

8. A system needs to be implemented by which supervisors are consistently held responsible for the actions of staff under their supervisory authority. **Supervisors must** also **be accountable** for information gathered by ombudsman related to the quality of service, their professionalism and the appropriateness of their human interactions with co-workers and clients.

9. Consumers, families and their advocates should have access to both an internal and external designated **ombudsman** whose responsibility is to independently collect complaints and reports of incidents, to preliminarily investigate those reports, and to provide summaries of its findings to both the executive team of the Department of Mental Health and to Missouri Protection and Advocacy. In addition, dedicated telephones should be readily available to consumers to allow unrestricted access for reporting to ombudsmen.

10. **All deaths** in DMH-funded facilities should be **reported to a coroner or medical examiner**. In addition, a dedicated DMH workgroup supervised by the executive team should review all deaths on a weekly basis and communicate any and all suspicious circumstances to the executive team.

11. The Department of Mental Health must explore multiple options for **external review** and involvement of family and natural supports in all aspects of service delivery. Facilitated by principles of open public disclosure and quality improvement, the department should provide meaningful venues for feedback and input.

12. The **relationship between regional centers and community service providers must be clarified**, and their work integrated to achieve efficiency and improve both accountability and quality of care. This will help address a problematic trend in which each presumes that control over programming lies with the other; the result of which is that effective leadership and decision-making are undermined.

13. Establish minimum requirements for facility directors to be present during night and weekend shifts in their respective facilities, as well as minimum requirements for **unannounced site visits** to all facilities.

14. Clear expectations must be maintained at all times about which incidents are reported to police, and surveillance of reporting to police (via cross-referencing of incident information and police reporting) must be maintained by DMH Central Office. A uniform **protocol for interface with law enforcement** must be established, based on legal precedent, and enforced.

15. The Department of Mental Health and the Governor must make a clear and unequivocal commitment to providing a **continuum of facility and community-based services that afford real choices** to all Missourians who require DMH services. The experiences of other state departments of mental health in the U.S. have demonstrated that there are clients with specific profiles of disability and or medical/psychiatric co-morbidity, who may be better served in dedicated centers than in community settings. Fear regarding loss of this option is a divisive element in undermining unified advocacy for severely- affected individuals served by DMH. Partnership with agencies that provide up-todate information to consumers and their families about quality residential services should be actively cultivated, and clients and their families should be assisted in the decision making process through a combination of individualized services: one-to-one mentoring, education regarding housing and provider resources, Medicaid training and advocacy, and support groups.

16. When funding is inadequate to provide service, the scope of service must be reduced, the public informed, and the **decisions about service reduction/prioritization should rest with the director of the department**. Such decisions should not be thrust upon the Regional Centers to "make do" with the money that is available.

17. The Mental Health Commission strongly supports **flexible funding options**, including the full implementation of Olmstead, which mandates that funding follow the consumer, allows their choice of support providers, including allowing families to care for their loved ones in their own homes utilizing natural supports.

18. The Department Director must **augment the executive team** in such a way that it improves inter-divisional communications, with adequate staffing to carry out the overarching mission of the Department of Mental Health.

19. **Video camera surveillance** should be strongly considered for all DMH facilities.

20. The Department should facilitate the development of **drug and mental health courts** which serve as a diversion from incarceration and have begun to successfully combine treatment with rehabilitation.

21. **Crisis Intervention Training** (CIT) should be further expanded in the state as a method to prevent persons with mental illness from being inappropriately placed in the criminal justice system. Police CIT teams can also prevent suicides and physical harm through intervention.

22. The Department must develop a comprehensive plan, including adequate staffing, for addressing the unique **mental health needs of aging DMH clients**.

23. The DMH **budget must stabilize**, recover (to compensate for relative losses suffered over the past decade), and be further supplemented to implement these recommendations. This will require legislative action. The "wait list" for MR/DD services, unavailability of appropriate inpatient and residential beds in the Division of Comprehensive Psychiatric Services (CPS), and inordinate delays in availability of treatment for ADA clients, represent a direct result of inadequacy of funding. In the interim, given the fact that these recommendations relate to abuse, neglect and safety, if it becomes apparent that adequate levels of funding are not available, we recommend a constriction of DMH services in order to direct funds to these critical efforts. The maintenance of safety must be an absolute priority in our system.

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